Division of Health Service Regulation

, ,		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING:	E CONSTRUCTION  01	(X3) DATE COMP	LETED
			I NAME OF THE PROPERTY OF THE		С		
		HAL035027		B. WING		02/0	3/2015
NAME OF F	PROVIDER OR SUPPLIER	ST	REET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ESSEX MANOR ASSISTED LIVING FACILITY  844 HIGHWAY 39 S.  LOUISBURG, NC 27549							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
C 000	Initial Comments			C 000			
		a Complaint Investigatio Cates and Billy Bryant o					
	or around April 1, 19 for Fifty-Six (56) be information, the fac required to meet the Standards and Reg Aged and Infirm (Wapplicable portions 13F for Adult Care I Beds and the 1967	is facility was first licens 969 as a Home for the Ads. Based on the above ility was surveyed and is a 1971 Minimum and Deputations for Homes for the 2005 Rules 10A Momes of Seven or Mor North Carolina State Bus on Section 407.1, Gro	aged esired he more, ) NCAC e				
	heat on one wing of	ged that the facility is with the building and that space sed to heat the resident	oace				
C 100	·	OBOTANTIATED.		C 190			
C 190	maintain 75 degree winter design condi following shall apply appliances. (1) Built-in electric	11 OTHER  a heating system sufficiency of the second system sufficiency of the system sufficiency of the system sufficiency of the system of t	er 3 e	Clan			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>			X3) DATE SURVEY COMPLETED		
		HAL035027	B. WING			C <b>03/2015</b>		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
ESSEX N	ESSEX MANOR ASSISTED LIVING FACILITY  844 HIGHWAY 39 S.  LOUISBURG, NC 27549							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE		
C 190	(k) This Rule shall facilities with the ex which shall not app  This Rule is not medure and the shall not appear	apply to new and existing apply to new and existing apply to existing facilities.  Let as evidenced by: Let as evi	C 190					
C 191	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (b) There shall be a maintain 75 degree winter design condi following shall apply appliances. (2) Unvented fuel to portable electric he (k) This Rule shall facilities with the ex which shall not app  This Rule is not me 1- Based on observ space heaters in re heat.  Findings include:	a heating system sufficient to s F (24 degrees C) under tions. In addition, the y to heaters and cooking ourning room heaters and aters are prohibited. apply to new and existing ception of Paragraph (e) ly to existing facilities.	C 191					

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Division of Health Service Regulation STATE FORM

UH6S21 If continuation sheet 2 of 3

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	CLIA ER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>		(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
				71. BOILBING.	•		С	
		HAL035027		B. WING		02/	03/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
ESSEX MANOR ASSISTED LIVING FACILITY  844 HIGHWAY 39 S.  LOUISBURG, NC 27549								
	ACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
ir in wi b- in no	the portion o ithout heat. A space hea Resident Ro	oom 127, which is		C 191				

Division of Health Service Regulation STATE FORM